CAJS-SP Date:_____

SUBJECT: New Hire Employment Package

The following forms need to be completed and their supporting documents forwarded to State Personnel.

_____ Personnel Action Request, 900-10
_____ Emergency Information Form, 900-7
_____ Designation of Person Authorized to Receive Warrants, STD 243
_____ Employee Action Request, STD 686
_____ Request for Nondisclosure of Employee Home Address,STD 677
_____ Certificate of Dependents, 900-12
Marriage Certificate (copy)
Birth Certificate for each child (copy)
_____ Statement of Service, 900-15
DD 214 for each period of Active Duty (copy)
_____ Federal Privacy Act Statement, 900-17
_____ Incompatible Activities Statement, 900-24
_____ Statement of SAD Status, 900-27
_____ Statement of Understanding, 900-27a
_____ Report of Medical History, STD 93
_____ Employment Eligibility Verification Form, I-9
_____ Oath of Allegiance, STD 689
_____ Acknowledgement of Receipt of Retirement Information Form, PERS-PUB-52
_____ Beneficiary Designation (CalPERS) STD 241
_____ Health Benefits Plan Enrollment, HBD-12
_____ Declaration of Health Coverage, HBD-12A
_____ Dental Enrollment Plan Authorization, STD 692
_____ Long Term Disability Plan (**Optional Benefit**)
_____ Group Legal Benefit Plan (**Optional Benefit**)

NAME:_____

LOCATION:_____ POSITION:_____

NOTES:_____

_____

_____

_____

State Active Duty
Personnel Action Request

1. Action Requested: ☐ Appointment ☐ Reassignment ☐ Promotion
☐ Pay Rate Change ☐ Extension ☐ Other

2. Requesting Activity: _____

3. Position:

a. TO: _____
Title SAD Grade Position Number

b. FROM: _____
(Not required for new appointments) Title SAD Grade Position Number

2. Individual's Name: _____
Last First MI

SSN: _____ Federally Recognized Military Grade: _____

Military Unit: _____

5. a. Proposed Effective Date: _____ b. Period: _____

6. Vice: _____

7. Requesting Official: _____

8. Recommend Approval: _____

9. Position Verified: _____ Date: _____
State Personnel Office Representative

10. Funds Verified: _____ Date: _____
Index: _____ Military Department Comptroller Representative

11. Approved: _____ Date: _____
AG or Representative

Remarks:
PEBD: _____
Duty Location: _____
Flag Check: _____
Phys Review : _____

OTAG Form 900-10 (May 2000)

Emergency Information Form

NAME: _____ SSN: _____ DOB: ____/____/____
First Middle Last Month Day Year

HOME ADDRESS: _____
No & Street

_____ PHONE: ( ) _____
City ZIP Area Code

Married _____ Single _____ Spouse's Name: _____

PERSON(S) TO BE NOTIFIED IN THE EVENT OF AN EMERGENCY:

_____ _____ _____
Name No & Street Phone

_____
City ZIP

_____ _____ _____
Name No & Street Phone

_____
City ZIP

_____ _____ _____
Name No & Street Phone

_____
City ZIP

I certify the above information is correct and understand that I must submit a revised form to the Directorate of State Personnel Programs when any of the above information changes.

_____
Signature

_____
Date

OTAG Form 900-7 (Revised Apr 89) All prior forms are obsolete

STATE OF CALIFORNIA

DESIGNATION OF PERSON AUTHORIZED TO RECEIVE WARRANTS (Gov. C., Sec. 12479)

STD. 243 (REV. 2-95)

Submit two copies of a completed form STD. 243 with original signatures to your personnel/payroll office.

EMPLOYEE NAME (First, Middle, Last)	SOCIAL SECURITY NUMBER
NAME OF EMPLOYING STATE AGENCY	CITY WHERE AGENCY LOCATED

Pursuant to Section 12479 of the Government Code, I hereby designate the following person who, notwithstanding any other provision of the law, shall be entitled **upon my death** to receive all state warrants that would have been payable to me had I survived. NOTE: Direct deposit payments are not subject to the provisions of this designation.

Important: This is NOT a designation for payment of death benefits and refund of employee retirement contributions. A form STD. 241, Beneficiary Designation (PERS), must be completed to file a designation with the Public Employees' Retirement System for death benefits.

DESIGNEE *(Must be 18 years of age or older)*

DESIGNEE NAME (First, Middle, Last)	SOCIAL SECURITY NUMBER	AGE	TELEPHONE NUMBER
ADDRESS	CITY AND STATE		ZIP CODE

I hereby revoke any previous designations filed by me.

If the above-named designee does not file a written request with the personnel/payroll office of my employing state agency/campus for such warrants within sixty (60) days after the date of my death, this designation shall be and become null and void .

This designation will remain in full force and effect during my employment with any California state agency/ campus until revoked in writing by me.

EMPLOYEE HOME ADDRESS	
CITY, STATE, ZIP CODE	
EMPLOYEE SIGNATURE *(Please sign both copies in ink)* ▷	DATE SIGNED

FOR AGENCY/CAMPUS USE ONLY

REVIEWED BY THE PERSONNEL/PAYROLL OFFICE AND FILED

SIGNATURE OF AUTHORIZED OFFICER ▷	
TYPED NAME	DATE

INSTRUCTIONS

1. Complete this form in duplicate; typewritten or in ink.
2. Show designee's full name; for example, "Mary Jane Smith," not Mrs. John E. Smith.
3. Verify that the form is complete and correct. No erasures or corrections may be made in the name of the designee. If any error has been made, complete a new set of forms.
4. Sign both copies in ink. Submit both copies to your personnel/payroll office. The duplicate copy will be returned to you for your records.
5. You may change your designation at any time by filing a new form STD. 243 with your personnel/payroll office.
6. You may completely revoke a designation at any time by submitting either a new form STD. 243 indicating "NONE" for the designee name or a letter to your employer. Two copies with original signatures are required.
7. Inform your personnel/payroll office when a change occurs in your designee's address.
8. You may wish to file a new designation upon any change in your marital status.

PRIVACY NOTICE

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by the employing personnel/ payroll office for the sole purpose of identifying the designee authorized to receive warrants payable to the employee had he/she survived.

Legal references authorizing maintenance of this information include the Government Code Section 12479 and the State Administrative Manual Section 8477.1-8477.27.

This form and all personal information contained therein is maintained by the employing personnel/payroll office. Employees have the right of access to copies of their Designation of Person Authorized to Receive Warrants form upon request.

Who is authorized to receive your pay warrant in case of death? Contact your personnel office to update your designee's name or address (Form STD. 243). See also retirement beneficiary information on reverse side of employee copy.

STATE OF CALIFORNIA

EMPLOYEE ACTION REQUEST

STD. 686 (REV. 7-99)

PERSONNEL OFFICE USE

A 01 AGENCY , 02 UNIT , 03 KEYED BY , 04 DATE KEYED

CHECK ONE OR MORE BOX(ES) AND COMPLETE LISTED SECTIONS. **RETURN COMPLETED FORM TO YOUR PERSONNEL OFFICE.** **USE BALL POINT PEN AND PRINT CLEARLY.** **NO CARBON REQUIRED.**

B

- ☐ 01 **New Employee** — SECTIONS C, E, F, G, H, I
- ☐ 03 **Withholding Allowance Change** — SECTIONS C, E, I
- ☐ 04 ***Address Change** — SECTIONS C, F, I
- ☐ 05 **Name Change** (Attach Substantiation) — SECTIONS C, D, I
- ☐ 07 **Birthdate Correction** — SECTIONS C, H, I

NOTE: Social Security Number and Last Name, First Name, and Middle Initial must be entered exactly as shown on Social Security card.

C

01 SOCIAL SECURITY NUMBER	02 EMPLOYEE LAST NAME	03 FIRST NAME AND MIDDLE INITIAL

NAME CHANGE

D FORMER NAME (Last, First and Middle)

WITHHOLDING ALLOWANCE CHANGE OR NEW EMPLOYEE

IMPORTANT Before completing Section E, you must read IRS Form W-4 and the applicable state tax form. (For California use Form DE-4.)

E

I. FEDERAL AND STATE ALLOWANCE – For Tax Purposes Only. If no tax should be withheld, complete Part IV or V only.

01 MARITAL STATUS FOR TAX PURPOSES ONLY *(Check One)*

☐ **SINGLE**

☐ **MARRIED**

02 ☐ **TOTAL** - Number of allowances you are claiming

NOTE: Employers must notify IRS if more than 10 allowances are claimed.

II. SPECIAL TREATMENT OF STATE ALLOWANCES – Complete boxes 03 thru 05 if you wish your State withholding to be different than what you claim for Federal withholding. *IF BOXES ARE NOT COMPLETED, CURRENT SPECIAL TREATMENT (IF ANY) WILL BE CANCELLED.*

03 MARITAL STATUS FOR TAX PURPOSES ONLY *(Check One)*

☐ **SINGLE**

☐ **MARRIED**

☐ **HEAD OF HOUSEHOLD**

04 ☐ **REGULAR ALLOWANCE(S)** Total you are claiming

05 ☐ **ADDITIONAL ALLOWANCE(S)** Total you are claiming

NOTE: Employers may be required to notify EDD if more than 10 allowances are claimed.

III. ADDITIONAL DEDUCTIONS – Complete box 06 and/or 07 if you wish additional Federal and/or State tax withheld from your wages. Part I (and Part II, if your State allowance claim differs from your Federal) must be completed. The first deduction will be made from your earnings for the pay period in which this form is processed. IF BOXES ARE NOT COMPLETED, CURRENT DEDUCTIONS (IF ANY) WILL BE CANCELLED.

I hereby authorize the State Controller to deduct monthly from my wages the additional Federal and/or State tax amount specified below. I understand that if boxes are not completed, current deductions, if any, will be cancelled.

06 $ **FEDERAL** ADDITIONAL DEDUCTION

07 $ **STATE** ADDITIONAL DEDUCTION

IV. EXEMPTION FROM WITHHOLDING – Check box 08 if you are eligible to claim exemption from withholding. No Federal or State income tax will be withheld from your wages. DO NOT COMPLETE PARTS I, II OR III. (See General Information on back of third page.)

08 ☐ *I claim exemption from withholding because of no tax liability.* Last year I did not owe any income tax and had a right to a full refund of ALL income tax withheld, AND this year I do not expect to owe any income tax and expect to have a right to a full refund of ALL income tax withheld.

NOTE: This exemption will automatically expire on February 15 of next year unless you file a new certification by January 31 of next year. **Employers are required to notify IRS if you earn more than $200 per week.**

V. NONTAXABLE WAGES – Check box 09 if wages you will receive are not subject to income tax withholding.

09 ☐ I claim that the wages I will be receiving from the State are either a 1) MINISTER OF A CHURCH in the exercise of his/her ministry, 2) NONIMMIGRANT ALIEN wages, or 3) DECEASED EMPLOYEE WAGES. Indicate reason (See General Information on back of third page.):

ADDRESS CHANGE OR NEW EMPLOYEE *See Back of Third Page

F

01 EMPLOYEE ADDRESS (Street, Rural Route or P.O. Box)	02 CITY	STATE	03 ZIP CODE

04 EMPLOYMENT LIST

☐ Check this box if your address is changing and your name appears on any departmental employment list. (See back of third page.)

NEW EMPLOYEE THIS INFORMATION MAY BE USED TO LOCATE PRIOR PUBLIC EMPLOYMENT SERVICE FOR STATE SERVICE CREDITS AND/OR RETIREMENT SYSTEM BENEFITS.

G

01 LAST EMPLOYED BY CALIFORNIA STATE AGENCY OR CAMPUS OF:	01 LAST NAME (if different)	03 SEPARATED MO YR	04 LAST EMPLOYED BY CALIFORNIA PUBLIC AGENCY OF: (City, County, Public School or Utility, etc.)	05 LAST NAME (if different)	06 SEPARATED MO YR

NEW EMPLOYEE OR BIRTHDATE CORRECTION

H BIRTHDATE MO DAY YR

EMPLOYEE SIGNATURE

I *I certify that the above information is true and correct and that I have read the IRS Form W-4 and the applicable state form. Under the penalties of perjury, I certify that the number of withholding exemptions and allowances claimed on this certificate does not exceed the number to which I am entitled. If claiming exemption from withholding, I certify that I incurred no tax liability for last year and that I anticipate that I will incur no liability this year.*

EMPLOYEE SIGNATURE	DATE

PERSONNEL OFFICE USE

J

REVIEWER'S SIGNATURE	
DATE	PHONE NO.

White — Personnel/Payroll Services Div. Yellow — Personnel Pink — Employee

OSP 99 30888

STATE OF CALIFORNIA

REQUEST FOR NONDISCLOSURE OF EMPLOYEE HOME ADDRESS

STD. 677 (NEW. 2-99)

PLEASE TYPE OR USE BALL POINT PEN - PRINT CLEARLY

NAME *(Last, First, Middle Initial)*	SOCIAL SECURITY NUMBER

Pursuant to Government Code Section 6254.3:

(a) The home addresses and home telephone numbers of state employees of a school district or county office of education shall not be deemed to be public records and shall not be open to public inspection, except that information may be made as follows:

(1) To an agent, or a family member of the individual to whom the information pertains.

(2) To an officer or employee of another state agency, school district, or county office of education when necessary for the performance of its official duties.

(3) To an employee organization pursuant to regulations and decisions of the Public Employment Board, except that the home addresses and home telephone numbers of employees performing law enforcement-related function shall not be disclosed.

(4) To an agent or employee of a health benefit plan providing health services or administering claims for health services to state, school districts, and county office of education employees and their enrolled dependents, for the purpose of providing the health services or administering claims for employees and their enrolled dependents.

(b) Upon written request of any employee, a state agency, school district, or county office of education shall not disclose the employee's home address or home telephone number pursuant to paragraph (3) of subdivision (a) and an agency shall remove the employee's home address and home telephone number from any mailing list maintained by the agency, except if the list is used exclusively by the agency to contact the employee.

CHECK APPROPRIATE BOX

☐ I request that my home address not be disclosed as provided by Government Code Section 6254.3(b). I understand that my home address can be disclosed to specified individuals or organizations under Government Code Sections 6254.3.

☐ I cancel my previous request of having my home address not be disclosed.

PRIVACY NOTICE

The Information Practices Act of 1977 (California Civil Code Section 1798.17) and the Federal Privacy Act (5 USC 552a, subd. (e)(3)) require this notice to be provided when collecting personal information from individuals. Information requested on this form, which includes the social security number, is used for the purposes of identification and the address withhold processing. Furnishing the requested information on this form is mandatory. Failure to provide the mandatory information may result in the address withhold action not being processed or being processed incorrectly.

Legal references authorizing the maintenance of this information include: Federal Internal Revenue Code (26 USC Sections 3402(a), 6011, 6051, and 6109) and the regulations thereto; and California Government Code Sections 12470 through 12479 and 16391 through 16395; delegated authority from the State Personnel Board; and delegated authority from the Trustees of the California State University.

Employees have the right to review their own personal information maintained by the State Controller's Office unless access is denied by law. Contact: Personnel/Payroll Services Division, State Controller's Office, P.O. Box 942850, Sacramento, CA 94250-5878.

EMPLOYEE SIGNATURE	DATE SIGNED

PERSONNEL OFFICE USE ONLY

REVIEWER'S SIGNATURE		TELEPHONE NUMBER ( )	DATE REVIEWED
AGENCY	**UNIT**	**KEYED BY**	**DATE KEYED**

Certificate of Dependents

Last Name	First Name	Initial	Grade	SSN

1. ☐ I have no dependents.

2. ☐ I certify the following named persons are my dependents for the purpose of receiving basic allowance for quarters:

a. **Lawful Spouse:**

NAME	ADDRESS	DATE OF MARRIAGE

b. **Children:**

NAME	ADDRESS	AGE	*STATUS

3. I further certify that my dependents are/are not occupying public (State or Federal) quarters without charge or if occupying such quarters the occupancy charge is $ _____ per month.

4. I will immediately notify the Directorate of State Personnel Programs of any changes in the status of my dependents.

_____
Signature

_____
date

*Legitimate
Step Child
Adopted

OTAG Form 900-12 (Apr 89)

Statement of Service

Date

I, _____
(Name) (Grade) (Social Security No.)

hereby certify that I am entitled to service credit in accordance with paragraph 10101, Military Pay and Allowance Entitlements Manual (See reverse), for service indicated below. I have attached documents to verify all periods of service other than California National Guard.

Service or component	From Day	From Month	From Year	To Day	To Month	To Year

AUTHENTICATION BY
STATE PERSONNEL OFFICE

SIGNATURE _____

_____

PART ONE
BASIC AND SPECIAL PAY
CHAPTER 1
SERVICE CREDITABLE

10101. Service Creditable

Basic pay varies with the number of years' service a member has credited. In computing cumulative years of service for this purpose, members are credited full-time service as follows:

a. Organizations in General. Active or inactive service as an officer, warrant officer, or enlisted member in any of the following:

- Air Force Reserve
- Air Force of the United States (without specification of component)
- Air National Guard
- Air National Guard of the United States
- Army of the United States (without specification of component)
- Army National Guard
- Army National Guard of the United States
- Army Reserve
- Coast Guard Reserve
- Marine Corps Reserve
- National Guard
- National Guard of the United States
- National Oceanic and Atmospheric Administration (see c. below)
- Naval Reserve
- Nurse Corps of the Public Health Service
- Nurse Corps Reserve of the Public Health Service
- Public Health Service
- Regular Air Force
- Regular Army
- Regular Army Reserve
- Regular Coast Guard
- Regular Marine Corps
- Regular Navy
- Reserve Corps of the Public Health Service

b. Nurse Service Before 16 Apr 1947. Creditable periods are those during which members held appointments as a nurse, Reserve nurse, or commissioned officer in the Army Nurse Corps or the Navy Nurse Corps, or the Reserve components thereof, as they existed before 16 Apr 1947.

c. National Oceanic and Atmospheric Administration (NOAA). Periods during which a member was an officer, deck officer, or junior engineer in the NOAA (includes periods served in the former corps of the Environmental Science Services Administration or the Coast and Geodetic Survey) is creditable service.

d. Service Counted on 10 Jan 1962. All service is creditable which, under any law in effect on 10 Jan 1962, was creditable in computing basic pay.

e. Service on Retired List or as Member of Fleet Reserve or Fleet Marine Corps Reserve. Creditable periods are those while on a temporary disability retired list, honorary retired list, or retired list of any uniformed service; and periods while entitled to retired pay, retirement pay, or retainer pay from any uniformed service or the Veterans Administration as a member of the Fleet Reserve or Fleet Marine Corps Reserve.

f. Women's Army Auxiliary Corps. Effective 7 Aug 1959, active service during the period 14 May 1942 through 29 Sep 1943 as a member of the Women's Army Auxiliary Corps (WAAC) may be counted if active military service is performed after 29 Sep 1943.

g. Army and Air Force Officers Restored To Duty Under Act of 29 Jun 1948. The period between date of removal and date of restoration of an Army or Air Force officer restored to the active list under the Army and Air Force Vitalization and Retirement Equalization Act of 1948 is creditable.

h. Retention for Medical Care After Expiration of Term of Service. Any period on and after 12 Dec 1941 when an enlisted member of an Armed Force is retained in service, after expiration of his or her term of service, for medical treatment or hospitalization for disease or injury incident to service and not due to his or her misconduct is creditable.

i. Service Before Attainment of Statutory Age for Enlistment. Any service which is otherwise creditable may be counted even if the service was performed before a member attained the statutory age for enlistment. Such service may not be counted if it is determined to be fraudulent and is voided for that reason.

j. Temporary Member of Coast Guard Reserve. Active service performed as a temporary member of the Coast Guard Reserve is creditable.

k. Army of the United States Commissions—World War II. Appointments made on and after 7 Dec 1941 in the Army of the United States, without component, under the Joint Resolution of 22 Sep 1941, are considered to have continued in effect through 31 Mar 1953 unless terminated before that date by administrative action or specific law. The period from the date of separation through 31 Mar 1953 may be credited for officers who:

(1) Did not have Reserve or National Guard status,

(2) Did not accept a Reserve commission, and

(3) Were separated on or before 31 Mar 1953 without vacating their AUS status.

l. Warrant Officer Appointment—World War II. For a temporary appointment as a warrant officer under section 3 of the Act of 21 Aug 1941, the period from separation from active duty through 1 Apr 1953 is creditable unless the appointment was expressly terminated earlier.

m. Flight Officer Appointment—World War II. For an appointment as a flight officer under the Flight Officer Act of 8 Jul 1942, the period from separation from active duty through 27 Oct 1952 is creditable unless the appointment was expressly terminated earlier.

n. Service Terminated by Desertion or Dishonorable Discharge. Service in an enlistment terminated by desertion or dishonorable discharge is creditable unless the enlistment was fraudulent and was voided for that reason.

o. Women's Army Corps. Appointments in the Women's Army Corps in the Army of the United States, without component, if not previously terminated, were terminated on 31 Mar 1953. Such service is creditable for basic pay purposes.

p. Service as Cadet or Midshipman. Cadet or midshipman service is creditable in computing basic pay of enlisted members. For officers, see table 1-1-1.

q. Detail to Agencies Such as the Agency for International Development (AID), Department of State. Service with AID and certain other agencies under agreement such as that between the Department of Defense and AID is creditable.

r. Reserve Officers' Training Corps. Service as a member of the Army, Navy, or Air Force Reserve Officers' Training Corps is creditable service as follows:

(1) Before 14 Oct 1964. Any member who had concurrent Reserve status.

(2) After 13 Oct 1964. An enlisted member who had concurrent Reserve status.

s. Aviation Midshipman. Service in the aviation midshipman program, Act of 13 Aug 1946, chapter 962, 60 Stat 1057, is creditable service for basic pay purposes effective on and after 26 Dec 1974.

t. Delayed Enlistment (Entry) Program:

(1) For a Regular Component. Service as an enlisted member in the Reserves before beginning active duty in a Regular component is creditable service if the member enlisted in the Reserve component before 1 Jan 1985.

(2) For a Reserve Component. All service as an enlisted member in the Reserves before beginning initial active duty for training is creditable.

Federal Privacy Act Information Statement

The Board of Administration, Public Employee's Retirement System, requires the disclosure of each member's Social Security account number on a mandatory basis to comply with Sections 6033 and 6041, Title 26, of the United States Code, and Sections 1.603-1(a)(3) and 1.604-2(b) of the Federal Tax Regulations, requiring reporting to the Internal Revenue Service of disbursements made by the System and to comply with its obligations under the Federal-State agreement imposed by Sections 404.1242, 404.1243, 404.1250, 404.1255 and 404.1256, Title 20, Code of Federal Regulations, requiring reporting to the Social Security Administration.

The Social Security account number is used for the following purposes and is included in the following documents:

1. Member indentification on membership files, documents, and correspondence.

2. Annual report to the Franchise Tax Board and to the Internal Revenue Service of interest on refunds where the interest paid to an individual is $600 or more.

3. Annual Statement of Member Contribution and Service Credit sent to employers for distribution to members.

4. Annual Listing of Member Contributions as of each June 30 sent to each employer.

5. All Refund Rolls submitted to the State Controller for processing.

6. Reports of benefit payments to the State Franchise Tax Board and to the Internal Revenue Service.

7. Annual return filed with the Internal Revenue Service.

8. Reports to the Internal Revenue Service of Federal income tax withheld from benefit payments.

9. Reports submitted to the Social Security Administration.

I have read the foregoing on _____
(date)

_____
(Signature)

INCOMPATIBLE ACTIVITIES STATEMENT

1. Each State agency is required to establish a statement of incompatible activities of employees and to advise employees periodically of those activities considered incompatible with State employment. The following activities are considered incompatible for State employees of the Military Department:

a. Providing confidential information to persons to whom issuance of such information has not been authorized, or using confidential information for personal gain or advantage or for the advantage of others.

b. Soliciting or accepting, directly or indirectly, any money, loan, employment, business, benefit or other thing of value (in addition to salary paid by the State) from anyone from whom it might be inferred as a gift to influence the State employee concerned.

c. Engaging in any employment which will prevent prompt response to a call to report to duty as required by department heads.

d. Providing, or using, the names of persons from office records for mailing list that has not been authorized.

e. Providing, or using, unit station lists for use in circulation or advertising of articles or services.

f. Using the prestige or influence of one's office for personal gain or advantage or for the advantage of others.

g. Using State time, facilities, records, equipment or supplies for personal use or gain.

h. Receiving or accepting money, gifts or favors for services rendered during State working hours.

i. Performance of an unofficial act that may later be subject to the officer's control, inspection, review, audit or enforcement in an official State capacity.

2. In addition to the above activities, employees are also reminded that the Government Code of the State of California prohibits the use of any public office or employment to either aid or obstruct any person from obtaining any elected position or from nomination for an elected position.

3. In order to insure that all employees of the Department are aware of the incompatible activities the inclosure one is provided for each employee to acknowledge receipt of this letter. Signed acknowledgements should be returned to this headquarters, attention: CASS.

I acknowledge that I have read and understand the above statement.

_____
Name

_____
Activity, Section, Branch, or Installation

_____
Date

Statement of State Active Duty Status

1. The authority for State Active Duty is the California Military and Veterans Code. It directs that the duties of the Officers, Warrant Officers and Enlisted Personnel of the Office of the Adjutant General shall conform to the duties prescribed by regulations of the Department of Defense for like positions in the Army, Air Force and Navy. All activities or installations operated by the Military Department are considered extensions of the Office of the Adjutant General and the same provisions apply to State Active Duty employees at those locations.

2. All members appointed to State Active Duty, regardless of Military affiliation, are advised that:

a. They are subject to call to duty 24 hours a day, seven days a week.

b. There is no entitlement to compensatory time off.

c. They are required to meet the same physical standards as prescribed for federally recognized National Guard members.

d. They must attain and maintain professional proficiency.

e. Federally recognized members of the National Guard will wear the appropriate Military Uniform while on duty and must comply with the appropriate military dress and grooming code.

f. Assignment to State Active Duty requires a release of their medical records for review and adjudication by proper military and medical authority.

g. Persons who are not appointed to permanent State Active Duty pursuant to CMVC 167 do not accrue any preferential rights in their employment status. In the event of a reduction in force, loss or decrease in funding, termination of a specific program or other event which affects their position, a person may be separated from State Active Duty status.

h. They are subject to the Uniform Code of Military Justice as assimilated into State law.

i. They may be prohibited from carrying forward accrued leave beyond a year as determined by the program director or other proper authority because of constraints and uncertainties related to program funding.

3. SAD MEDICAL RECORD RELEASE: I hereby release any and all of my medical records or reports to The Adjutant General or the State Personnel Programs Director of the California National Guard from any physician or treatment facility. This release is effective as long as I am performing State Active Duty with the California National Guard or am a member of the California Army or Air National Guard. I understand that this release is to provide information to The Adjutant General or a properly designated individual to ascertain my condition or ability to perform State Active Duty.

A photocopy of this release may serve as an original writing.

4. I acknowledge having read the above statement and agree to comply with the established provisions.

Printed Name: _____

Signature of Soldier/Airman: _____

Position Title: _____

Date: _____

Statement of Understanding
State Active Duty - Special Programs

1. I understand that I have been placed on orders to Temporary State Active Duty (SAD) pursuant to the California Military and Veterans Code (CMVC) Section 142.

2. I understand that I am subject to the Uniform Code of Military Justice as incorporated into the CMVC for purposes of military discipline.

3. I understand that temporary SAD is not a permanent status and that my orders may be administratively terminated at anytime if the need for personnel performing duty changes or if my performance is determined to be substandard.

4. I understand that personnel on SAD do not have a right to or guarantee of continuation on orders beyond the duty ending date indicated on the initial order.

Printed Name: _____

Signature of Soldier/Airman: _____

Position Title: _____

Date: _____

STANDARD FORM 93 (EG)
REV. OCTOBER 1974
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

APPROVED
OFFICE OF MANAGEMENT AND BUDGET No. 29-R0191

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME - FIRST NAME - MIDDLE NAME		2. SOCIAL SECURITY OR IDENTIFICATION NO.
3. HOME ADDRESS *(No., street or RFD, city or town, State, and ZIP CODE)*		4. POSITION *(title, grade, component)*
5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION	7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Include ZIP Code)*

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint exists)*

9. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
		Lived with anyone who had tuberculosis
		Coughed up blood
		Bled excessively after injury or tooth extraction
		Attempted suicide
		Been a sleepwalker

10. DO YOU *(Please check each item)*

YES	NO	(Check each item)
		Wear glasses or contact lenses
		Have vision in both eyes
		Wear a hearing aid
		Stutter or stammer habitually
		Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
			Scarlet fever, erysipelas				Cramps in your legs				"Trick" or locked knee
			Rheumatic fever				Frequent indigestion				Foot trouble
			Swollen or painful joints				Stomach, liver, or intestinal trouble				Neuritis
			Frequent or severe headache				Gall bladder trouble or gallstones				Paralysis (include infantile)
			Dizziness or fainting spells				Jaundice or hepatitis				Epilepsy or fits
			Eye trouble				Adverse reaction to serum,				Car, train, sea or air sickness
			Ear, nose, or throat trouble				drug, or medicine				Frequent trouble sleeping
			Hearing loss				Broken bones				Depression or excessive worry
			Chronic or frequent colds				Tumor, growth, cyst, cancer				Loss of memory or amnesia
			Severe tooth or gum trouble				Rupture/hernia				Nervous trouble of any sort
			Sinusitis				Piles or rectal disease				Periods of unconsciousness
			Hay Fever				Frequent or painful urination				
			Head injury				Bed wetting since age 12				
			Skin diseases				Kidney stone or blood in urine				
			Thyroid trouble				Sugar or albumin in urine				
			Tuberculosis				VD - Syphilis, gonorrhea, etc.				
			Asthma				Recent gain or loss of weight				
			Shortness of breath				Arthritis, Rheumatism or Bursitis				
			Pain or pressure in chest				Bone, joint or other deformity				
			Chronic cough				Lameness				
			Palpitation or pounding heart				Loss of finger or toe	12. FEMALES ONLY: HAVE YOU EVER			
			Heart trouble				Painful or "trick" shoulder or elbow				Been treated for a female disorder
			High or low blood pressure				Recurrent back pain				Had a change in menstrual pattern

13. WHAT IS YOUR USUAL OCCUPATION?

14. ARE YOU *(Check one)*

☐ Right handed ☐ Left handed

EXCEPTION TO SF 93
APPROVED BY OIRM 12/83
Designed using Perform Pro, WHS/DIOR, Jul 94

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
		15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.
		B. Inability to perform certain motions.
		C. Inability to assume certain positions.
		D. Other medical reasons *(If yes, give reasons.)*
		16. Have you ever been treated for a mental condition? *(If yes, specify when, where, and give details.)*
		17. Have you ever been denied life insurance? *(If yes, state reason and give details.)*
		18. Have you had, or have you been advised to have, any operations? *(If yes, describe and give age at which occurred.)*
		19. Have you ever been a patient in any type of hospitals? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*
		20. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details)*
		21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*
		22. Have you ever been rejected for military service because of physical, mental, or other reasons? *(If yes, give date and reason for rejection.)*
		23. Have you ever been discharged from military service because of physical, mental, or other reasons? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*
		24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.
I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

25. Physician's summary and elaboration of all pertinent data *(Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)*

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

REVERSE OF STANDARD FORM 93

INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1 - Employee. All employees, citizens noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1 personally.

Section 2 - Employer. For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record: 1)** document title; **2)** issuing authority; **3)** document number, **4)** expiration date, if any; and **5)** the date employment begins. Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. **However, employers are still responsible for completing the I-9.**

Section 3 - Updating and Reverification. Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/ reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.

and

- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B and:
  - examine any document that reflects that the employee is authorized to work in the U.S. (see List A **or** C),
  - record the document title, document number and expiration date (if any) in Block C, and
  - complete the signature block.

Photocopying and Retaining Form I-9. A blank I-9 may be reproduced provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire **or** one (1) year after the date employment ends, whichever is later.

For more detailed information, you may refer to the INS Handbook for Employers, (Form M-274). You may obtain the handbook at your local INS office.

Privacy Act Notice. The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 U.S.C. 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Naturalization Service, the Department of Labor, and the Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Reporting Burden. We try to create forms and instructions that are accurate, can be easily understood, and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1)** learning about this form, 5 minutes; **2)** completing the form, 5 minutes; and **3)** assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to both the Immigration and Naturalization Service, 425 I Street, N.W., Room 5304, Washington, D. C. 20536; and the Office of Management and Budget, Paperwork Reduction Project, OMB No. 1115-0136, Washington, D.C. 20503.

U.S. Department of Justice
Immigration and Naturalization Service

OMB No. 1115-0136
Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE. It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins

Print Name: Last	First	Middle Initial	Maiden Name
Address *(Street Name and Number)*		Apt. #	Date of Birth *(month/day/year)*
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):
A citizen or national of the United States
A Lawful Permanent Resident (Alien # A_____)
An alien authorized to work until___/___/___
(Alien # or Admission #_____)

Employee's Signature | Date *(month/day/year)*

Preparer and/or Translator Certification. *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature | Print Name

Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

Section 2. Employer Review and Verification. To be completed and signed by employer. **Examine one document from List A OR examine one document from List B and one from List C** as listed on the reverse of this form and record the title, number and expiration date, if any, of the document(s)

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date *(if any)*: __/__/__		__/__/__		__/__/__
Document #: _____				
Expiration Date *(if any)*: __/__/__				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* **___/___/___and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment).**

Signature of Employer or Authorized Representative | Print Name | Title

Business or Organization Name | Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

Section 3. Updating and Reverification. To be completed and signed by employer

A. New Name *(if applicable)* | B. Date of rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title:_____ Document #:_____ Expiration Date (if any):__/__/__

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative | Date *(month/day/year)*

LISTS OF ACCEPTABLE DOCUMENTS

LIST A

Documents that Establish Both Identity and Employment Eligibility

1. U.S. Passport (unexpired or expired)
2. Certificate of U.S. Citizenship *(INS Form N-560 or N-561)*
3. Certificate of Naturalization *(INS Form N-550 or N-570)*
4. Unexpired foreign passport, with *I-551 stamp or* attached *INS Form I-94* indicating unexpired employment authorization
5. Alien Registration Receipt Card with photograph *(INS Form I-151 or I-551)*
6. Unexpired Temporary Resident Card *(INS Form I-688)*
7. Unexpired Employment Authorization Card *(INS Form I-688A)*
8. Unexpired Reentry Permit *(INS Form I-327)*
9. Unexpired Refugee Travel Document *(INS Form I-571)*
10. Unexpired Employment Authorization Document issued by the INS which contains a photograph *(INS Form I-688B)*

OR

LIST B

Documents that Establish Identity

1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address
2. ID card issued by federal, state, or local government agencies or entities provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor, or hospital record
12. Day-care or nursery school record

AND

LIST C

Documents that Establish Employment Eligibility

1. U.S. social security card issued by the Social Security Administration *(other than a card stating it is not valid for employment)*
2. Certification of Birth Abroad issued by the Department of State *(Form FS-545 or Form DS-1350)*
3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. Native American tribal document
5. U.S. Citizen ID Card *(INS Form I-197)*
6. ID Card for use of Resident Citizen in the United States *(INS Form I-179)*
7. Unexpired employment authorization document issued by the INS *(other than those listed under List A)*

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

STATE OF CALIFORNIA

OATH OF ALLEGIANCE AND DECLARATION OF PERMISSION TO WORK FOR PERSONS EMPLOYED BY THE STATE OF CALIFORNIA

STD. 689 (REV. 12/84) (COMPLETE PARTS 1 AND 3 OR PARTS 2 AND 3)

PART 1—OATH OF ALLEGIANCE

WHO MUST SIGN OATH—As required in Section 3 of Article XX of the Constitution of California, every State employee except legally employed noncitizens, must sign an oath or affirmation before he or she enters upon the duties of his or her State employment. Noncitizens are required to possess a Declaration of Permission to Work. If an alien employee becomes a naturalized citizen, an oath must then be obtained and filed.

WHEN OATH MUST BE SIGNED—As required in Government Code Section 3102, all public employees and all volunteers in any disaster council or emergency organization accredited by the California Emergency Council must sign an oath or affirmation before entering upon the duties of their employment. For intermittent, temporary or emergency employments, an oath or affirmation may, at the discretion of the employing agency, be effective for all successive periods of employment which commence within one calendar year from the date of the oath.

WHERE OATHS ARE FILED—As required in Government Code Section 3105, all oaths for public employees and all volunteers in any disaster council or emergency organization accredited by the California Emergency Council, shall be filed in the official employee file within 30 days of the date the oath is executed. The oath is considered a public record.

FAILURE TO SIGN OATH—As stated in Government Code Section 3107, no compensation or reimbursement for expenses incurred shall be paid to any public employee or any volunteer in any disaster council or emergency organization accredited by the California Emergency Council unless such public employee has taken and subscribed to the oath or affirmation.

PENALTIES (Government Code)

"3108. Every person who, while taking and subscribing to the oath or affirmation required by this chapter, states as true any material matter which he knows to be false, is guilty of perjury, and is punishable by imprisonment in the state prison not less than one nor more than 14 years."

"3109. Every person having taken and subscribed to the oath or affirmation required by this chapter, who, while in the employ of, or service with, the state or any county, city, city and county, state agency, public district, or disaster council or emergency organization advocates or becomes a member of any party or organization, political or otherwise, that advocates the overthrow of the government of the United States by force or violence or other unlawful means, is guilty of a felony, and is punishable by imprisonment in the state prison."

(TYPE OR PRINT NAME OF EMPLOYEE)

I, _____, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter.

PART 2—DECLARATION OF PERMISSION TO WORK

I am a lawful permanent resident alien of the United States. ☐ YES ☐ NO

If NO, please read the following:

I hereby certify, that I have permission to work in this country and have declared any restrictions placed upon me in this regard by the United States government to the appointing power.

PART 3—SIGNATURE AND CERTIFICATION (NO FEE MAY BE CHARGED FOR ADMINISTERING)

SIGNATURE OF EMPLOYEE

▶

STATE DEPARTMENT OR AGENCY | SUBDIVISION/UNIT

Taken and subscribed before me this

_____ Day of _____

SIGNATURE OF AUTHORIZED OFFICIAL

▶

TITLE

(SEAL)

Oath may be administered by a person having general authority by law to administer oaths—or may be administered by the appointing power, or by a person for whom written authorization to witness oaths has been executed by the appointing power. The appointing power maintains a file of such authorizations.

84 34317

Information Acknowledgment Form

Acknowledgment of Receipt of Retirement Information

I have received the information and election package on the State Miscellaneous or Industrial 2% at age 55 and State Second Tier 1¼% at age 65 retirement formulas (PERS-MSD-350).

Member Signature

Social Security Number

Member Printed Name

CalPERS Membership Date

Date

Employer

Daytime Telephone Number

This form must be completed, signed, and returned to your personnel clerk who will forward it to CalPERS. THIS IS NOT AN ELECTION DOCUMENT.

This information and election package was given to the above employee.

on:

Date

by:

Personnel Office Staff

( )

Phone Number

Please return this form to:
California Public Employees' Retirement System
Member Services Division, Unit 841
P.O. Box 942704
Sacramento, CA 94229-2704

BENEFICIARY DESIGNATION (CalPERS)

STD. 241 (REV. 9-2000) (PAGE 1)

INFORMATION AND INSTRUCTIONS

PLEASE READ CAREFULLY

I. If you die before you retire, the Public Employees' Retirement Law provides for payment of specific Death Benefits to your surviving beneficiaries. Please see your personnel officer for a description of the benefits. The benefits are payable to the following beneficiaries:

A. **If you are eligible for retirement on date of death or if you are a State member with at least 20 years of State service credit,** the benefits will be payable to your surviving spouse to whom you have been married for one year (whether or not you were still living together at the time of your death) or, if none, to your unmarried children under age 18.

B. If you are a safety or industrial member and your death is determined to be industrial, the benefit will be payable to your surviving spouse (whether or not you were still living together at the time of your death) or, if none, to your unmarried children under age 22.

C. If A and B do **not** apply and there is no valid Beneficiary Designation on file at the time of death, the benefits will be payable to your survivors in the following order:

1. Your surviving spouse (whether or not you were still living together at the time of your death); or, if none,
2. Natural and adopted children, including a natural child adopted by another, share and share alike; or, if none,
3. Parents, share and share alike; or, if none,
4. Brothers and sisters, share and share alike; or, if none,
5. Your estate (if probated, or subject to probate), or, if not,
6. Your trust (if one exists), or, if not,
7. Stepchildren, share and share alike; or, if none,
8. Grandchildren, including step-grandchildren, share and share alike; or, if none,
9. Nieces and nephews, share and share alike; or, if none,
10. Great-grandchildren, share and share alike; or, if none,
11. Cousins, share and share alike.

D. If A and B do not apply and there **is** a valid Beneficiary Designation on file at the time of death, the benefits will be payable to the beneficiary(ies) you designate on the form.

II. Please use the attached Beneficiary Designation if you wish to designate beneficiaries other than the statutory beneficiaries shown above, or in a different order. You may designate or change the beneficiaries you name at any time prior to retirement.

A. You may name as beneficiary any person or persons, your estate or a corporation. (A corporation must be incorporated under the laws of a state.)

B. You may designate a trust as your beneficiary. However, if you wish to designate a trust, the following information should be provided: The name of the trust, date of trust, and name and address of the person with whom the trust is on file.

C. Do **not** name a guardian for a minor child. If the money is payable to a minor child, the court-appointed guardian will be responsible for any benefits paid to the child.

III. Your Beneficiary Designation will be revoked automatically by any of the following events:

1. Marriage;
2. Dissolution or annulment of marriage if ***initiated*** **after** the beneficiary designation form was submitted; or
3. Birth or adoption of a child; or
4. Termination of employment that results in a refund of your contributions.

Unless you submit a new Beneficiary Designation, benefits will be paid to your statutory beneficiaries as shown in item 1 above.

Please refer to your CalPERS Member Booklet for further details on the above pre-retirement death benefits. A copy of the booklet may be obtained from your personnel office or from your nearest CalPERS office.

INSTRUCTIONS

SEE REVERSE SIDE OF THIS PAGE

BENEFICIARY DESIGNATION (CalPERS)

STD. 241 (REV. 9-2000)) (REVERSE, PAGE 1)

INSTRUCTIONS

1. Press firmly and print clearly with ball point pen or type all information requested. If you make an error, make the necessary correction (do not use correction fluid) and initial the change.
2. Prepare a rough draft list on scratch paper of whom you wish to name, the relationship, social security number and complete address. (The name must be the full given name, as "Mary Jane Smith"; not, "Mrs. John Edward Smith.)
3. Enter on the form the full names of your beneficiaries, relationship, social security number and the complete address for each. (If this form does not provide enough space, you may attach additional sheets provided you indicate whether you are designating "primary" or "secondary" beneficiaries.)
4. You must sign the form in the presence of a witness (other than a named beneficiary) with your full name, as "John Edward Smith".
5. Your spouse must sign the form, in the presence of a witness, to acknowledge the names of the beneficiaries you are designating. **IMPORTANT** -- If you are unable to obtain your spouse's signature, you MUST complete and return the BAS-800D, Justification for Non-Signature of Spouse form included in this packet.
6. Have the witness clearly sign the form.
7. Enter the date you signed the form and your current mailing address.
8. Mail original and duplicate of the completed form to the California Public Employees' Retirement System at the address shown.
9. After review and processing, the approved member copy will be returned within six weeks for your records.

PLEASE NOTE:

Your Beneficiary Designation **CANNOT** be processed without either your spouse's signature, or the completed "Justification for Non-Signature of Spouse" (BAS-800D) form attached. The Beneficiary Designation may be invalid if the form is not dated or if corrections/erasures are not initialed. The effective date of the Beneficiary Designation is the date the completed form is received by the Retirement System.

IMPORTANT INFORMATION

The Information Practices Act of 1977 and the Federal Privacy Act require the California Public Employees' Retirement System to provide the following information to individuals who are asked to supply information. The information requested is collected pursuant to the Government Code Sections (20000, et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Failure to supply all of the requested information may result in the System being unable to perform its functions regarding your status. Portions of this information may be transferred to: state and public agency employers, California State Attorney General, Office of the State Controller, Teale Data Center, Franchise Tax Board, Internal Revenue Service, Workers' Compensation Appeals Board, State Compensation Insurance Fund, County District Attorneys, Social Security Administration, beneficiaries of deceased members, physicians, insurance carriers, and various vendors who prepare microfiche/microfilm for CalPERS. Disclosure to these parties is done in strict accordance with current statutes regarding confidentiality.

You have the right to review your membership files maintained by the California Public Employees' Retirement System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P. O. Box 942702, Sacramento, CA 94229-2702.

STATE OF CALIFORNIA

BENEFICIARY DESIGNATION (CalPERS)

STD. 241 (REV. 9-2000)

		(This Space for CalPERS Use Only)	
TO	BOARD OF ADMINISTRATION PUBLIC EMPLOYEES' RETIREMENT SYSTEM P. O. BOX 942711, SACRAMENTO, CA 94229-2711	ORIGINAL FORM RECEIVED BY CalPERS ON *(Date)*	
		ORIGINAL FORM APPROVED BY CalPERS ON *(Date)*	
FROM	MEMBER'S FULL NAME *(Please print)*	CURRENT EMPLOYER	
	SOCIAL SECURITY NUMBER	BIRTHDATE	TELEPHONE NUMBER

PRIMARY BENEFICIARIES

I hereby designate the following person(s) who survive me as BENEFICIARIES for Death Benefits under the Public Employees' Retirement Law in the event of my death prior to retirement. I understand that if I die after becoming eligible for service retirement, this beneficiary designation may be superseded in certain cases and benefits paid according to law to my eligible surviving spouse or minor children; or, if my death is determined to be industrial, special death benefits will be paid in the manner prescribed by law. If no percentage (%) is given, benefits will be paid SHARE AND SHARE ALIKE.

FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS *(Number and Street)*		*(City)*		*(State)*	*(ZIP Code)*
FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS *(Number and Street)*		*(City)*		*(State)*	*(ZIP Code)*
FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS *(Number and Street)*		*(City)*		*(State)*	*(ZIP Code)*

SECONDARY BENEFICIARIES

In the event I survive the person(s) named above, I hereby designate the following person(s) who survive me, as BENEFICIARIES. If no percentage (%) given, benefits will be paid SHARE AND SHARE ALIKE.

FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS *(Number and Street)*		*(City)*		*(State)*	*(ZIP Code)*
FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
ADDRESS *(Number and Street)*		*(City)*		*(State)*	*(ZIP Code)*

Should I survive all of the persons named above, I understand that the benefits payable on account of my death will be paid to my statutory beneficiaries, or to such other beneficiary or beneficiaries that I may hereafter designate in writing to the Board of Administration, all in accordance with the applicable provisions of law.

BY THIS BENEFICIARY DESIGNATION, I HEREBY REVOKE ANY PREVIOUS DESIGNATION I HAVE FILED. I UNDERSTAND THAT MY MARRIAGE, INITIATION OF DISSOLUTION OR ANNULMENT OF MY MARRIAGE, OR THE BIRTH OR ADOPTION OF A CHILD SUBSEQUENT TO THE DATE I EXECUTE THIS FORM WILL AUTOMATICALLY VOID THIS DESIGNATION.

MEMBER			SPOUSE
SIGNATURE *(Member's Full Name)*		DATE	*By signing this beneficiary designation form, I acknowledge the information entered by my spouse.*
ADDRESS *(Number and Street)*			SPOUSE'S SIGNATURE *(IMPORTANT - if no signature or certification, the attached BAS-800D must be completed)*
(City)	*(State)*	*(Zip Code)*	WITNESS *(Cannot be a beneficiary)*
☐ *I certify under penalty of perjury that I am not legally married (never married, divorced, widowed).*			WITNESS' SIGNATURE

CalPERS
Benefit Services Division
P.O. Box 942711
Sacramento, CA 94229-2771
(800) 352-2238

JUSTIFICATION FOR NONSIGNATURE OF SPOUSE

Pursuant to Government Code Section 21261, the member's current spouse must be made aware of the selection of benefits or change of beneficiary made by the member. The spouse of a CalPERS member must acknowledge the submission of a request for refund of contributions; election of retirement optionqal settlement; and designation of beneficiary for Pre-retirement Death Benefits.

If a spouse's signature does not appear on one of the above-mentioned documents, the following information **MUST** be completed by the member and submitted with the application/form.

SOCIAL SECURITY NUMBER | MEMBER'S NAME (TYPED OR PRINTED)

APPLICATION SUBMITTED

BENEFICIARY DESIGNATION (CalPERS), STD. 241

☐ I am not legally married *(never married, divorced, widow/er).*

☐ I am married, but my spouse did not sign the form because either:

- ☐ I do not know and have taken all reasonable steps to determine the whereabouts of my spouse; **OR,**
- ☐ My spouse has been advised of the application and has refused to sign the written acknowledgement; **OR,**
- ☐ My spouse is incapable of executing the acknowledgement because of an incapacitating mental or physical condition; **OR**
- ☐ My spouse has no identifiable community property interest in the benefit; **OR**
- ☐ My spouse and I have executed a marriage settlement agreement which makes the community property law inapplicable to the marriage.

I certify under penalty of perjury that the foregoing information is true and correct.

MEMBER'S SIGNATURE | DATE SIGNED

CALIFORNIA PERS

Public Employees' Retirement System
Post Office Box 942714
Sacramento, CA 94229-2714

HEALTH BENEFIT PLAN ENROLLMENT FORM

PERS—HBD-12 (Rev. 10/93)

DO NOT SEND MEDICAL CLAIMS TO THIS ADDRESS

PERS USE ONLY—DOCUMENT REFERENCE NUMBER

▶ PLEASE TYPE ◀

1. TYPE OF ACTION (Check One)
   - ☐ a. NEW enrollment
   - ☐ b. CHANGE of coverage
   - ☐ c. CANCEL all coverage

2. SOCIAL SECURITY NUMBER — —

3. SPOUSE'S SOCIAL SECURITY NUMBER — —

4A. Name (FIRST) (MI) (LAST)

Mailing Address

City, State, ZIP

4B. RESIDENCE ZIP CODE (If different from 4A)

5. ☐ Please check if Permanent Intermittent Employee (applies to active State employees only)

6. SEX ☐ Male ☐ Female

7. MARRIED ☐ Yes ☐ No

8. PLAN CODE

9. NAME OF HEALTH PLAN

10. GROSS PREMIUM $

11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP

12. PRIOR PLAN CODE

13. PRIOR HEALTH PLAN

14. Permitting Event Code

15. Permitting Event Date Mo. Day Year

16. EFFECTIVE DATE Mo. Day Year 01

ACTION CODE	LIST ALL PERSONS (including self) TO BE ENROLLED IN:	DATE OF BIRTH Mo.	Day	Yr.	Family Relationship	CODE
	17. BASIC PLAN (FIRST) (MI) (LAST)				SELF	
ACTION CODE	18. SUPPLEMENTAL PLAN (FIRST) (MI) (LAST)	DATE OF BIRTH Mo.	Day	Yr.	Relationship	CODE

19. CHECK ONE

- ☐ I **DO NOT** wish to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above in Items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to CANCEL the Health Benefits Plan as shown in Items 12 and 13 above.

20. EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse of employee copy) ▶

21. DATE SIGNED Mo. Day Year

▶ PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22–27 ◀

22. DEDUCTION PLAN CODE

23. Type of action (Check One) 1. ☐ New 2. ☐ Cancel 3. ☐ Change

24. PAY PERIOD Month Year

25. PARTY CODE

26. EMPLOYEE DESIGNATION

27. BARGAINING UNIT

28. AGENCY NAME (or Retirement System)

29. PAYROLL OFFICE CODE

30. AGENCY CODE

31. UNIT CODE

32. I hereby certify under penalty of perjury as follows:

That I am a duly appointed, qualifed and acting officer of the above named agency, and that payment by the agency as provided by Sections 22825–22832 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.

SIGNATURE OF HEALTH BENEFITS OFFICER ▶

33. Date received in employing office Mo. Day Yr.

34. PHONE NUMBER ( )

35. REMARKS

_____ of _____ Forms

OSP 98 15838

WHITE—HBD PINK—AGENCY BLUE—EMPLOYEE

CalPERS

Declaration of Health Coverage
HB-12A (01/01/98)

California Public Employees' Retirement System
Health Benefit Services Division
P.O. Box 942714; Sacramento, CA 94229-2714
(800) 237-3345

(INSTRUCTIONS ON REVERSE)

EMPLOYEE INFORMATION SOCIAL SECURITY NUMBER	NAME (FIRST) (MIDDLE) (LAST)

PART A ☐ I elect to enroll myself and all eligible dependents.	
PART B-1 ☐ I elect to enroll myself. My eligible dependents have other health insurance coverage.	If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits Program. You must request enrollment with 60 days from the date you lose coverage. **If you do not request enrollment within 60 days, you or your dependents must wait at least 90 days or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.**
PART B-2 ☐ I elect to enroll myself and eligible dependents. I also have eligible dependents who have other health insurance coverage.	
PART C-1 ☐ I decline enrollment for myself and my eligible dependents because we have other health insurance coverage.	
PART C-2 2. ☐ I decline enrollment for myself and/or my eligible family members for reasons other than having health insurance coverage.	You can request enrollment for yourself and/or your dependents at any time. **You must wait at least 90 days after you request enrollment or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.**

PART B: If you are currently enrolled in the Health Benefits Program and you acquire new dependents or if a court orders health coverage for your dependent, you can add your new dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

PART C: If you are not currently enrolled in the Health Benefits Program and you acquire new dependents as a result of marriage, birth, adoption, or placement for adoption, or if a court orders health coverage for your dependent, you can enroll yourself and dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

Special rules apply to retirement and death. Please read the back of this form carefully.

Member's Signature
HB-12A (01/98)

Date Signed
Original: Employee's Personnel File

Health Benefits Officer's Signature
Copy: Employee

INSTRUCTIONS - DECLARATION OF HEALTH COVERAGE (HB-12A)

Please contact your Health Benefits Officer if you have any questions regarding the HB-12A	
Employee Information	Complete with the appropriate employee information.
PART A:	Mark this box if you are: a) Enrolling in the Health Benefits Program and have no dependents, or b) Enrolling yourself and ALL eligible dependents in the Health Benefits Program.
PART B-1:	Mark this box if you are: a) Enrolling yourself only, your dependents have other health insurance coverage, or b) Canceling your dependents' coverage because they have other health insurance coverage.
PART B-2:	Mark this box if you are: a) Enrolling yourself and SOME of your dependents, your other dependents have health insurance coverage, or b) Canceling coverage for some of your dependents because they have other health insurance coverage.
PART C-1:	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage, you have no dependents and you have other health coverage, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents and you have other health insurance coverage.
PART C-2:	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage for reasons other than having health insurance coverage and you have no dependents, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents for reasons other than having health insurance coverage.

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include marriage, acquisition of a dependent child, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

Special rules for retirement and death:

Consider these points as you decided whether to enroll, decline, or cancel enrollment for yourself or dependents.

- If you are not enrolled in a CalPERS-sponsored health plan on the date you separate employment, you will not be eligible for health benefits into retirement.
- If your retirement date is over 120 days from your separation date, you will not be eligible for health benefits into retirement.
- If you die and your eligible family members are not enrolled on your CalPERS-sponsored health plan at that time, they will not be eligible for continued enrollment in a CalPERS-sponsored health plan if they qualify for monthly survivor benefits.

STATE OF CALIFORNIA

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD. 692 (REV. 11-98)

D

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY–SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A

1. TYPE OF ACTION

☐ **NEW** - ENROLLING IN A PLAN FOR THE FIRST TIME *(Complete Sections A, B, and D)*

☐ **CANCEL** - CANCELLING COVERAGE FOR ALL ENROLLEES *(Complete Sections A, C, and D)*

☐ **CHANGE** - CHANGING PLANS OR DEPENDENT COVERAGE *(Complete Sections A, B, C, and D)*

2. SOCIAL SECURITY NUMBER

3. SPOUSE'S SOCIAL SECURITY NUMBER

4. NAME *(First)* *(Middle)* *(Last)*

ADDRESS *(Number and Street)*

(City, State, and Zip)

5. CHECK IF PERMANENT INTERMITTENT EMPLOYEE ☐

6. MARITAL STATUS ☐ MARRIED ☐ SINGLE

7. SEX ☐ MALE ☐ FEMALE

SECTION B

1. NAME OF DENTAL PLAN

2. PROVIDER/FACILITY NUMBER *(If applicable)*

3. WHEN CHANGING FAMILY MEMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED, AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR D (DELETE) BESIDE THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN *(include self)* (First) (Middle) (Last)	DATE OF BIRTH MONTH	DAY	YEAR	FAMILY RELATIONSHIP
					SELF

SECTION C

1. PRIOR DENTAL PLAN NAME

SECTION D

1. CHECK APPROPRIATE BOX

☐ I DO NOT WISH TO ENROLL IN A DENTAL PLAN

☐ I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.

☐ I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE *(See Privacy Information on reverse of employee copy.)*

2. DATE SIGNED

SECTION E *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

1. EMPLOYER DED. CODE	2. DENTAL ORG. CODE	3. EMPLOYEE DEDUCTION AMOUNT	4. PARTY CODE	5. STATE SHARE AMOUNT	6. PAY PERIOD MONTH / YEAR	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
☐ CSU-150 ☐ NON-CSU-351		$		$				$

COMPLETE ON CANCELLATIONS ONLY 10. PRIOR EMPLOYER DED. CODE	11. PRIOR DENTAL ORG. CODE	12. PERMITTING EVENT DATE MONTH / DAY / YEAR	13. PERMITTING EVENT CODE	14. EFFECTIVE DATE OF ACTION MONTH / DAY / YEAR	15. AGENCY CODE	16. UNIT CODE	17. AGENCY NAME OR RETIREMENT SYSTEM *(IF RETIRED)*
☐ CSU-150 ☐ NON-CSU-351				- 1 -			

18. REMARKS

19. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Dental Insurance Program.

20. TELEPHONE NUMBER *(Indicate if CALNET or give Area Code)*

21. DATE RECEIVED IN EMPLOYING OFFICE MONTH / DAY / YEAR

WHITE - To Controller YELLOW - To Carrier PINK - To Agency GREEN - To Employee